North Dakota Level of Care/Continued Stay Review Determination Form*

(*To be maintained in medical record. Transfer a copy with the resident)

Name: _____ **Payment Status:** _____ **Requested Screen Type:**

NF ☐ Swing Bed ☐ HCBS ☐ TBI ☐
Personal Care ☐

c/o: _____ **Medicaid #:** _____

Status Change: MI ☐ MR ☐

Address: _____ **SS#:** _____ **DOB:** _____

Requesting Facility:_____

City/State/Zip: _____ **Gender:** _____ **Marital Status:** _____

Contact Person: _____

County: _____ **Height:** _____ **Weight:** _____

Address: _____

Current Living Arrangement: _____ **Contact Person/Phone:** _____

City/State/Zip: _____

Phone: _____

In determining level of care, the individual must require or meet a minimum of one of the criteria listed in "Section A" **or** two criteria included in "Section B" **or** criterion in "Section C" **or** all the criteria in "Section D":

Section A:

☐ 1) Nursing Facility stay is, or is anticipated to be, temporary for receipt of Medicare Part A benefits. Nursing facility stay may be based on this criterion for no more than fourteen (14) days beyond termination of Medicare Part A benefits;

☐ 2) The individual is in a comatose state;

☐ 3) The individual requires use of a ventilator for at least six (6) hours a day;

☐ 4)The individual has respiratory problems that require regular treatment, observation, or monitoring that can only be provided by or under the direction of a registered nurse (or in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse) and she/he is incapable of self care;

☐ 5) The individual requires constant help at least 60% of the time with at least two (2) of the following Activities of Daily Living(ADL's): **Toileting** (process of using toileting equipment and cleansing self), **eating** (process of getting food from receptacle into the body), **transferring** (process of moving to and from bed, chair, toilet), **locomotion** (process of navigating home environment with or without adaptive devices, as appropriate). Constant help is required if the individual requires a caregiver's continual presence or help, without which the activity would not be completed. Identify and describe: _____

☐ 6)The individual requires aspiration for maintenance of a clear airway;

☐ 7) The individual has dementia, physician diagnosed or supported with corroborative evidence for at least 6 months, and as a result of that dementia, the individual's dementia, the individual's condition has deteriorated to the point that a structured, professionally staffed environment is needed to monitor, evaluate, and accommodate the individual's changing needs. Describe needs and provide date of onset/initial diagnosis: _____

Section B (If no criteria in Section A are met, an applicant or resident is medically eligible for NF level of care if at least two of the following criteria apply):

☐ 1) The individual requires administration of a prescribed: a) injectable medication; or b) intravenous medication and solutions on a daily basis; or c) routine oral medications, eye drops, or ointments on a daily basis. List relevant medications: _____

☐ 2) The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse (or, in the case of a facility which has secured a waiver the requirements of 42 CFR 483.30(b), a licensed practical nurse). Identify diagnosis and describe services needed: _____

☐ 3) The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatments (e.g., gait training, bowel and bladder training) which are provided at least five (5) days per week. Identify restorative procedures required: _____

☐ 4) The individual needs administration of feedings by nasogastric tube, gastrostomy, jejunostomy, or parenteral route. Specify: _____

CONTINUED ON FOLLOWING PAGE

NORTH DAKOTA LEVEL OF CARE (CONTINUED)

Name:_____

Level of Care Screen (Continued)

☐ 5) The individual requires care of decubitus ulcers, stasis ulcers, or other widespread skin disorders. Specify:

_____
_____
_____

☐ 6) The individual requires constant help at least 60% of the time with one (1) of the following: **Toileting** (process of using toileting equipment and cleansing self), **eating** (process of getting food from receptacle into the body), **transferring** (process of moving to and from bed, chair, toilet), **locomotion** (process of navigating home environment with or without adaptive devices, as appropriate). Constant help is required if the individual requires a caregiver's continual presence or help, without which the activity would not be completed. Specify and describe:

_____
_____
_____
_____

Section C:

If no criteria in Section A and/or insufficient criteria in Section B was met, an applicant/ resident who applies to or resides in a nursing facility for nongeriatric individuals with physical disabilities may demonstrate that nursing facility level of care is necessary if:

☐ 1) The individual is determined to have restorative potential. Describe:

_____
_____

Section D:

If no criteria in "Section A", "Section B", or "Section C" are met, the individual who applies for care in a nursing facility may demonstrate that a nursing level of care is medically necessary if:

☐ 1) The individual has an acquired brain injury, including anoxia, cerebral vascular accident, brain tumor, infection, or traumatic brain injury; and

☐ 2) As a result of the brain injury, the individual requires direct supervision at least eight (8) hours a day

Additional Notes/Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Send to: Dual Diagnosis Management (DDM), Attn ND LTC; 220 Venture Circle; Nashville, TN 37228; Phone: 877/431.1388; Fax: 877/431.9568

Determination (DDM Use Only)

☐ **Requested Additional Information**

Request Date_____Received Date_____

Screen Type

☐ NF ☐ SB ☐ HCBS ☐ TBI ☐ Personal care

Outcome

☐ **Approved** Time Limited? ☐ No ☐ Yes, # of days_____

If time limited, start date_____ end date_____

☐ **Denied** On-site Required? ☐ No ☐ Yes

Onsite Referral Date_____Due_____

_____ _____
DDM Reviewer Signature Date

_____ _____
NDLOC0603 DDM MD Signature (If applicable) Date